Kentucky Department for Medicaid Services

Drug Review Decisions

The following chart provides a summary of the recommendations that were made by the Pharmacy and Therapeutics (P&T) Advisory Committee at the July 17, 2003, meeting and the final decisions made after review of the recommendations.

	Description of Recommendation	Final Decision by the Commissioner and the Secretary
	Review of Non-steriodal anti-inflammatory drugs (not Cox-IIs) Recommend that the following modification be made to the NSAID PDL with the addition of salicylate as a preferred agent. In addition, all quantity limits on these products should be lifted: <u>PREFERRED DRUGS</u> (brand name requires PA where generic is available) <u>Immediate Release Dose Forms</u> Salicylate (Disalcid) Etodolac (Lodine) Flurbiprofen (Ansaid) Indomethacin (Indocin) Meclofenamate (Meclomen) Oxaprozin (Daypro) Sulindac (Clinoril) Diclofenac sodium (Voltaren) Fenoprofen (Nalfon) Ibuprofen (Motrin) Ketoprofen (Orudis) Naproxen (Anaprox, Naprosyn) Piroxicam (Feldene) <u>Extended Release</u> Indomethacin SR (Indocin SR) Naproxen (EC Naprosyn) <u>NON-PREFERRED DRUGS</u> <u>Immediate Release Dose Forms</u> Diclofenac Potassium (Cataflam) Diclofenac Na. /Misoprostil (Arthrotec) Ketorolac (Toradol) Meloxicam (Mobic) Tolmetin (Tolectin) Mefenamic Acid (Ponstel) Nabumetone (Relafen) <u>Extended Release Dose Forms</u> Diclofenac SR (Voltaren XR) Ketoprofen SR (Oruvail) Etodolac SR (Lodine XL) Naproxen (Naprelan)	Recommendations Approved
	Class review of Hepatitis C Medication Management - Pegylated Interferon-alfa, Ribavirin Recommend placing duration of therapy limit of 16 weeks on peg-interferon and ribavirin and require a genotype and qualitative HCV RNA serum assay for continuation of treatment. Those patients who have an EVR (2 log decrease in viral load at 12 weeks) will be approved for continuation of treatment for an additional 32 weeks for viral genotype 1 or 4 for a total of 48 weeks. (Proof of) An EVR is not required for genotype 2 or 3, but will receive a total of 24 weeks of therapy based on documentation of genotype. In addition, Copegus is the preferred ribavirin in conjunction interferon, or peg-interferon.	Recommendations Approved

	Description of Recommendation	Final Decision by the Commissioner and the Secretary
	Class Review of 5-HT3 Antiemetic Agents to Treat Severe Nausea / Vomiting Recommend placing quantity limits on the 5-HT3 antagonists and on Emend with the quantity limits based on the average quantity per treatment session, an average of four (4) sessions per month, and on available package size of each product. Requests for higher doses would require PA. Quantity limits are as follows: Zofran : 4mg and 8mg: 12 tablets per month 24mg: 4 tablets per month Liquid: 50ml/month Injection: 4 vials 20ml (40mg); and 8 vials 2ml (4mg) Kytril: 1mg tablets: 8 tablets per month Liquid: 30ml/month Injection: 8 vials 1mg/1ml Anzemet: 50mg and 100mg tablets: 5 tablets per month Injection: 4 vials 100mg/5ml; and 8 ampules 12.5mg/0.625ml Emend: 4 Tri-packs (12 tablets) per month	Recommendations Approved